metrial ablation, low intensity pulsed ultrasound (LIPUS) and negative pressure wound therapy were investigated further, through interviews with country and product experts. **RESULTS:** Hospital and ambulatory sales could not be separated but some differences in total sales between countries were apparent. Where HTA processes existed they appeared to slow down access to new technologies. Several interviewees highlighted a lack of expertise on local purchasing groups where decisions are often based upon in-year budget considerations which restrict access to some cost effective technologies. Even where new technologies are found to be cost effective, DRG based funding systems are insufficiently flexible to establish new out-patient fee levels. Hospitals have no financial incentive to treat patients in an out-patient setting if the procedure cost exceeds existing out-patient DRG fees. This prevents innovative technologies from being used in the most appropriate way and cost saving opportunities are missed. **CONCLUSIONS:** Health providers need to demonstrate new technologies are cost effective before commissioners agree funding outside DRG based fee systems. The negotiation process would be more efficient if commissioners pooled expertise for reviewing cost-effectiveness evidence and fed their conclusions directly to DRG code and Tariff setting authorities. New DRG codes and higher out-patient tariffs for cost effective technologies that enable a switch to ambulatory care could incentivise hospitals to revise care pathways. Benefits will include lower procedure costs than in-patient treatment or improved outcomes for patients.

HEALTH CARE USE & POLICY STUDIES - Disease Management

PHP8
A SURVEY OF "JOINT WORKING" BETWEEN THE PHARMACEUTICAL INDUSTRY AND THE NATIONAL HEALTH SERVICE IN THE UK

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OBJECTIVES: An increasingly high-profile policy initiative being driven by the Department of Health (DoH), the Association of the British Pharmaceutical Industry (ABPI) and National Health Service (NHS) stakeholders, "joint working" encompasses a variety of forms of collaboration between the industry and the NHS in the UK (UK). This study sought to characterise the current landscape for joint working in the UK by surveying the types of projects being undertaken by participants. **METHODS:** Secondary research was conducted to establish a comprehensive list of joint-working projects; the websites of major pharmaceutical companies, the ABPI, the DoH and other NHS stakeholders were surveyed for any references to joint working. A classification system was created to segment projects by type of scheme, therapeutic area(s) and stakeholders involved. This segmentation was analysed to look for qualitative trends in the UK joint-working environment. **RESULTS:** A key finding of the study is that many pharmaceutical companies are now active in joint working. Joint-working projects encompass a broad range of therapeutic areas, with most companies active in areas in which they have assets. These projects can be segmented into a number of different categories, including those centered on service (re)design, service appraisals in light of current guidelines, and techniques to better manage or educate patients. Pharmaceutical companies are also active in providing training or other types of support to health care professionals and managers within the NHS. **CONCLUSIONS:** The joint-working policy initiative in the UK has resulted in a significant number of partnerships within the NHS in recent years. These projects are varied in nature, and have seen the pharmaceutical industry and the health service cooperate in innovative ways. Increasingly, companies are willing to share their expertise and resources in projects which have indirect benefits for them in terms of the market access of their products.

HEALTH CARE USE & POLICY STUDIES - Drug/Device/Diagnostic Use & Policy

PHP9
DRUG PRICING IN BOSNIA AND HERZEGOVINA

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OBJECTIVES: To compare and explain current drug pricing systems in Bosnia and Herzegovina (B&H) for reimbursed drugs by Health Insurance Funds (HIF) and out-of-pocket drugs. **METHODS:** Analysis of reimbursement list and legislation on acces to drugs in B&H is performed. We analysed pricing for reimbursed drugs and out-of-pocket drug prices regulation and explain cost structure. **RESULTS:** General drug pricing system is set by Agency for medicines and medical devices of B&H. Prices are defined as maximal wholeseler price (WSP) and pricing is based on referal pricing. Referal countries are Croatia, Serbia, Slovenia, Austria and Italy. B&H price must be set at level of referal price with addoption for patented drug (100%), originator (95%) and generics (90%). Prices are revised each year and published on Agency website. Maximal wholeseler margine is up to 8%, while retail margine is set by entity laws. In Federation maximal retail margine is 25% while in Republic of Srpska margine is fixed on 20% add on WSP. Reimbursable price in Republic of Srpska is defined as lowest offered price for each INN and presentation. Price difference can be paid by patient depenting on preferences. Reimbursed prices for drugs included into Federal reimbursement list is set by nagotiation process with manufacturers. All prices should be revised and adopted annualy to the Agency published prices. Retail margine is not applicable for reimbursed drugs because pharmacy is paid by HIF per prescription according to the agreement. **CONCLUSIONS:** Even there is intention to unify pharmaceutical market and drug prices in Bosnia and Herzegovine, there are still differences in price and related pricing regulations. Recently published Rule on price control by state Agency should contribute to equalisation of prices in Bosnia and Herzegovina.

PHP10
THE EFFECT OF LAW FOR ECONOMICAL USE OF MEDICATIONS 2006 ON THE AVERAGE TURNOVER OF COMMUNITY PHARMACIES BETWEEN 2007-2010

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OBJECTIVES: In 2006 a law for the economical use of medications was introduced into the Hungarian legislation. This law – among others – facilitated the foundation of new pharmacies. The aim of our study is to analyse the effect of that legislation on the annual turnover of community pharmacies. **METHODS:** Data were derived from the pharmaceutical database of the Hungarian Health Insurance Fund Administration (OEP), the only health care financing agency in Hungary. We analysed the 5 years period between 2006-2010. The main indicator of our analyses was the annual turnover of pharmacies calculated on health insurance reimbursement according to the number of population of different settlements. **RESULTS:** The average annual turnover – calculated on health insurance reimbursement – of a community pharmacy was 176.8 million Hungarian Forint (HUF) or 669011 EUR in 2006 with significant differences according to the size of population. Pharmacies located in small cities had a much lower average annual turnover (0-499 population: 105.6 million HUF; 500-999: 41.9 million HUF; 1000-1999: 63.2 million HUF), while the turnover of pharmacies located in bigger cities, was significantly higher (10000-49999 population: 217.6 million HUF; 50000-99999: 231.9 million HUF; over 100000: 241.6 million HUF). The average annual turnover of a community pharmacy was 135.4 million Hungarian Forint (HUF) or 491627 EUR in 2010, i.e. 76.6 % of 2006's turnover. Between 2006 and 2010, the annual turnover of pharmacies in small villages (population 0-1999) varied between 86.1-103.7 % while those of big cities (population over 10000) changed to 66.9-76.5 %. **CONCLUSIONS:** The annual turnover of pharmacies in small villages was significantly lower than those of big towns during the study period 2006-2010. However, the annual turnover of small villages' pharmacies decreased moderately compared to pharmacies located in bigger towns because new pharmacies were established in bigger towns.

PHP11
AVAILABILITY AND PRICING OF INNOVATIVE PHARMACEUTICALS IN THE TOP 5 EUROPEAN PHARMACEUTICAL MARKETS

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OBJECTIVES: In an attempt to assess time to market and price levels of innovative drugs, we surveyed market availability and drug prices for a basket of drugs in the top 5 European pharmaceutical markets. **METHODS:** The market availability of 125 innovative drugs – approved between July 2009 and April 2012 by the European Medicines Agency – in France, Germany, Italy, Spain, and the United-Kingdom was analysed. Within this sample, prices of 10 drugs marketed in each of the market studied were compared. **RESULTS:** Most of the drugs included in our sample are marketed in Germany and the UK, 59% and 54% respectively. In Spain, France and Italy this figure drops to 39%, 33%, and 32% respectively. It should be highlighted that only 14% of the drugs was available in all the markets analysed. Prices are commonly the highest in Germany and lower in Italy or the UK. Additionally, while for an identical drug, most examples show significant price differences between the markets studied, a few showed that the price corridor was relatively narrow. **CONCLUSIONS:** Our results show that Germany and the UK – where prices have not been directly controlled – are still prioritised, while market entry occurs at a later stage in France, Italy and Spain. The fact that large price differences are still observed between countries means that there is still flexibility in terms of pricing strategies. The pricing procedure implemented in 2011 in Germany, has not had an immediate impact on prices - which are still the highest. However, an impact is already being felt on market access. Several innovative drugs were not launched in Germany when the price outcome was expected to be unsuccessful.

PHP12
PATENTED DRUG EXTENSION STRATEGIES ON HEALTH CARE SPENDING: A COST-EVALUATION ANALYSIS

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OBJECTIVES: Drug manufacturers, facing patent protection termination, have developed strategies to maintain market share. These include marketing evergreening drugs (slow release formulations, single isomer chiral molecules, or structural analogues/combinations of original patented drugs) and offering high rebates to hospitals that use brand-name or evergreening drugs. Our objective was to assess the financial impact of evergreening drug prescriptions in the community, and to measure the impact of a hospital restrictive drug formulary (RDF) on health care expenditures. **METHODS:** We combined three administrative registries from the canton of Geneva, Switzerland to analyse all prescriptions between January 2000 and December 2008. We developed cost-minimisation models calculating evergreening and brand drug prescriptions at their corresponding generic selling price equivalents. ARIMA models measured the spillover effect of hospital prescription patterns into the community. Spillover costs were compared to hospital savings. Summary results were aggregated on a yearly basis and extrapolated to the canton of Geneva. **RESULTS:** Evergreening drug prescriptions resulted in an extra cost of €20,172,000 over the study period. Brand drug extra costs decreased from €6,555,000 (2004) to €1,403,000 (2008), but were offset by the increase in evergreening drug prescriptions ("squeezing the balloon" phenomenon). The final extra cost to the health care system was €42,147,000. The use of a hospital RDF to control cost resulted in global savings of €837,000. However, listing drugs on the hospital RDF decreased health care system savings to €31,000 only due to increased prescription